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March 24, 2006

VIA HAND DELIVERY & ELECTRONIC MAIL

Board of Directors
Dirigo Health Agency
Attn: Lynn Theberge
211 Water Street
Augusta, ME 04333-0053

RE: Determination of Aggregate Measurable Cost Savings for the Second Assessment Year (2007)

Dear Ms. Theberge:

Enclosed for filing please find two hard copies of the Maine Automobile Dealers Association Insurance Trust's Pre-Hearing Brief.

Thank you for your attention to this matter.

Very truly yours,

Roy T. Pierce

RTP/ryp
Enclosure
cc: James E. Smith, Esq. (via U.S. Mail and electronic mail)
William H. Laubenstein, III, Esq. (via U.S. Mail and electronic mail)
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STATE OF MAINE
DIRIGO HEALTH AGENCY

IN RE: DETERMINATION OF AGGREGATE MEASURABLE COST SAVINGS FOR THE SECOND ASSESSMENT YEAR (2007)	)))))	MAINE AUTOMOBILE DEALERS ASSOCIATION INSURANCE TRUST'S PRE-HEARING BRIEF

NOW COMES the Intervenor, the Maine Automobile Dealers Association Insurance Trust (the "Trust"), by and through its undersigned counsel, and, pursuant to the Board's Procedural Order No. 3 dated February 22, 2006, submits the following pre-hearing brief.

I. ARGUMENT

At the core of this proceeding is the following statutory language from the Dirigo Health Act (the "Act"):

> [T]he [Dirigo] Board shall determine annually ... the aggregate measurable cost savings, including any reduction or avoidance of bad debt and charity care costs to health care providers in this state as a result of the operation of Dirigo Health and any increased MaineCare enrollment due to an expansion in MaineCare eligibility occurring after June 30, 2004.

24-A M.R.S.A. § 6913(1)(A). The Act, therefore, clearly and unambiguously provides that there are but two sources of "aggregate measurable cost savings"—(1) cost savings that are the result of "the operation of Dirigo Health" and (2) those that are the result of increased MaineCare enrollment due to expansions in eligibility.

As part of its effort to satisfy its burden of proving the existence of aggregate measurable cost savings ("AMCS"), the DHA retained Mercer Government Human Services Consulting ("Mercer"). For the sum of $900,000 (on top of the $975,000 paid last year), Mercer created a methodology (the "Mercer Methodology") by which it contends the Board can determine the

existence of AMCS and ultimately quantify those savings. According to the DHA, the Mercer Methodology reveals cost savings in seven areas:

1. The decision by hospitals to voluntarily limit cost increases to no more than 4.5% as measured by case mix adjusted discharge ("CMAD");

2. The avoidance or reduction in bad debt and charity care costs ("BD/CD");

3. The MaineCare Adults Expansion;

4. The so-called "Woodwork Effect";

5. Reduced spending on hospital and non-hospital infrastructure as a result of a Certificate of Need Moratorium and limits on the Capital Investment Fund ("CON/CIF");

6. The time value of money stemming from hospitals' early receipt of increased Prospective Interim Payments ("PIP"); and

7. Increases in Medicaid payments to be paid to physicians.

(Dirigo Health Savings Offset Payment: Year 2 – Methodology and Data Sources "Mercer Report" at 2-5, 7-8). The Mercer Methodology, however, is fundamentally flawed.

A. Reliance On BD/CC And The MaineCare Adults Expansion

Two of the savings categories set forth in the Mercer Methodology actually have textual support in the Act for their consideration in the Board's determination of AMCS—BD/CC and the MaineCare Adults Expansion. Mercer's reliance on these two categories of alleged cost savings is largely misplaced.

First, the period for which Mercer proposes to measure BD/CC is calendar year ("CY") 2006. (Mercer Report at 19). The year currently under review, however, is state fiscal year ("SFY") 2005; *i.e.*, July 1, 2004 through June 30, 2005. In connection with the proceedings before the Superintendent of Insurance (the "Superintendent") involving the First Assessment Year, Docket No. INS-05-700, Mercer and the DHA claimed BD/CC savings of $2.7 million for

CY 2005. See Final Report: Dirigo Health Savings Offset Payment (SOP): Methodology and Calculations dated September 19, 2005 at 20 and Appendix H. Of the $43.7 million in AMCS upheld by the Superintendent, $2.7 million was attributed to BD/CC savings claimed for CY2005. See Decision and Order dated October 29, 2005 at 9, 13, 14. Moreover, the Board used the $43.7 million in AMCS upheld by the Superintendent as the basis for its recent assessment of a Savings Offset Payment. See Minutes of November 22, 2005 Meeting of the Dirigo Health Agency Board of Directors. The DHA, therefore, has already received the benefit of cost savings attributable to BD/CC for the time period under review here. By seeking to measure BD/CC for CY 2006, the DHA has assumed the role of the nine-year old looking for an advance on his allowance.

Second, to the extent that the MaineCare Adults Expansion results in an increase in enrollment due to an expansion in MaineCare eligibility, the Trust concedes that any savings related thereto may be considered by the Board for inclusion in its AMCS determination. The MaineCare Adults Expansion, however, did not take effect until May 1, 2005. Thus, assuming there are any savings from the MaineCare Adults Expansion, only those savings for the two-month period from May 1, 2005 through June 30, 2005 are properly includable in the AMCS determination.

B. The Mercer Methodology Includes Categories Of Supposed Cost Savings Having Nothing To Do With "The Operation Of Dirigo Health"

As it did in the proceedings for the First Assessment Year, Mercer asserts that AMCS properly includes all savings "related to the Dirigo Health Reform Act." (Mercer Report at 8). Following up on this theme, in his Pre-Filed Testimony, Steven Schramm described Mercer's work on this project as follows:

> Mercer assisted the Dirigo Health Agency establish the methodologies to be used for determining if there was [sic] any savings associated with Year 2 of the Dirigo program, *including Dirigo's directly and indirectly related components*, as described in the Dirigo Health Reform Act and related amendments. Our work with the Agency included examining the statute, cataloging the various impacts of Dirigo and *Dirigo-related activities*, identifying the assorted populations and time frames impacted, and finally recommending proposed methodologies to capture those impacts.

(Schramm Pre-Filed at 2) (emphasis added). In short, it is Mercer's belief, and the foundation on which the Mercer Methodology rests, that any cost savings having any relation to the Act is appropriately considered in determining aggregate measurable cost savings.

As noted above, however, the Act requires that in order to be included in the calculation of AMCS, the measure must be "as a result of the operation of Dirigo Health." Under the Act, "Dirigo Health" is "an independent executive agency to arrange for the provision of comprehensive, affordable health care coverage to eligible small employers, including the self-employed, their employees and dependents and individuals on a voluntary basis." 24-A M.R.S.A. § 6902. Thus, as used in the Act, "Dirigo Health" refers to the *agency* created by the Act, *i.e.*, the DHA, not to the Act. In the calculation of aggregate measurable cost savings, therefore, the focus must be on the agency alone, not the Act itself.

Moreover, it is not enough for a measure of cost savings to be related to the DHA to be considered in the calculation of aggregate measurable cost savings; rather to be included in the calculation, an item of cost savings must be related to the *operation* of the DHA. A central tenet of statutory construction is that statutes must be interpreted in accordance with the plain meaning of the language used. See In re Wage Payment Litig., 2000 ME 162, ¶ 4, 759 A.2d 217, 220-21. The plain meaning of "operation" is the state of being functional. See THE NEW WEBSTER'S ENCYCLOPEDIC DICTIONARY OF THE ENGLISH LANGUAGE at 467-68 (1997). Therefore, in order to be properly included in the measure of aggregate measurable cost savings, a cost savings must

be attributable to the functioning of the DHA. The DHA, however, was established to provide comprehensive and affordable health coverage to those eligible and to monitor and improve the quality of health care in Maine. See 24-A M.R.S.A. §§ 6902 and 6908.

The Mercer Methodology includes a variety of purported cost savings having nothing to do with the DHA's operation as a health insurance provider. In fact, the Mercer Methodology reveals that, whether by inclination or by express direction, Mercer has bought into the DHA's "ends justify the means" approach to calculating AMCS.

1. CMAD

In its original form, the Act asked various participants in Maine's health care market to adhere to certain voluntary limits on their businesses. Among the requests, the Legislature asked hospitals to limit their cost increases to no more than 3.5% as measured by expenses per case mix adjusted discharge ("CMAD"). See P.L. 2003, ch. 469, § F-1(1)(B). The original voluntary CMAD target expired on June 30, 2004. Id. Although the Legislature set a new voluntary CMAD target of 110% of the forecasted increase in the hospital market basket index, that target applies only to fiscal years beginning *on or after* July 1, 2005. See P.L. 2005 ch. 394, § 4. The year under review here, however, is July 1, 2004 through June 30, 2005. There is, therefore, no statutory voluntary CMAD target applicable to the year under review.

Undeterred, Mercer proposes to include in its AMCS methodology savings allegedly attributed to hospital adherence to a *voluntary* 4.5% CMAD target established by the Maine Hospital Association for July 1, 2004 through June 30, 2005. (Mercer Report at 2, 8; Schramm Pre-Filed at 5, 6). Mercer's inclusion of purported CMAD savings in the AMCS determination is inconsistent with the stated premise on which its methodology rests. As articulated by Mercer, a category of savings is properly includable in the determination of AMCS if it has some relation

to the Act. (Mercer Report at 8; Schramm Pre-Filed at 2). As noted above, and in contrast to both the immediately proceeding and succeeding assessment years, the Act contains *no* voluntary CMAD target applicable to *this* assessment year. One cannot, in one breath, argue that AMCS includes those savings related in any way to the Act, and, in the next, argue that AMCS includes a savings category whose prior textual basis in the Act has been removed. In short, not only is CMAD for this assessment year not related to the operation of the DHA, it is not even related to the Act.

2. The "Woodwork Effect"

As one of its cost savings categories Mercer identifies cost savings attributable to the "woodwork effect" of MaineCare members who were previously uninsured or underinsured coming "out of the woodwork" to enroll in MaineCare "through the Dirigo single-point-of-entry enrollment process." Mercer proposes to calculate these supposed savings by multiplying the increase in MaineCare enrollment since June 30, 2004 assumed to be attributable to Dirigo (the basis for the assumption is not explained) by a per member per month cost figure. (Mercer Report at 22). Once again, Mercer is taking liberties with the statutory language.

As noted above, one permissible element of cost savings for inclusion in the Dirigo Board's determination of aggregate measurable cost savings consists of cost savings attributable to "any increased MaineCare enrollment *due to an expansion in MaineCare eligibility* occurring after June 30, 2004." 24-A M.R.S.A. § 6913(1)(A) (emphasis added). Mercer, however, bases its MaineCare Woodwork savings on the increase in the number of persons enrolled in MaineCare since June 30, 2004, that it assumes is due to *publicity* surrounding Dirigo (Schramm Pre-Filed at 7; Russell Pre-Filed at 2), rather than on the increase in MaineCare enrollment attributable to an expansion of MaineCare *eligibility* as required by the express language of the

Act. In so doing, Mercer improperly ignores the limitation "due to an expansion in MaineCare eligibility." See Handyman Equip. Rental Co., Inc. v. City of Portland, 1999 ME 20, ¶ 9, 724 A.2d 605, 607-608 (meaning must be given to every word, term, and phrase in a statute).

Moreover, Mercer suggests that it believes that savings attributable to the Woodwork Effect on the private insurance market are properly included in the Board's AMCS determination. (Mercer Report at 8). Mercer, however, did not provide any information as to how one could determine the method by which Mercer plans to quantify any such savings. Rather, it stated only that it "will be analyzed once data is available." (Mercer Report at 18). In their Pre-Filed testimony filed two days later, however, Mercer's witnesses indicated that Mercer is not proposing a Private Insurance Woodwork methodology. (Schramm Pre-Filed at 7; Russell Pre-Filed at 3-4).

3. CON/CIF

Mercer includes in its methodology so-called CON/CIF savings. (Mercer Report at 24-26). Such savings are not attributable to the operation of the DHA. Indeed, as the basis for including CON/CIF in AMCS, Mercer cites not to the Act or even to another part of the Insurance Code, but to the Moratorium imposed on spending for new buildings and equipment in 2003. (Mercer Report at 24; Schramm Pre-Filed at 7-8, 16-17).

However, the Certificate of Need Act is administered by the Department of Human Services, and was passed a year prior to the Act's passage. See P.L. 2001, ch. 664. Similarly, the Moratorium was issued on May 5, 2003, a month *before* the Act's passage. Cost savings initiatives resulting from legislation and administrative rules enacted prior to the statute to which the DHA owes its very creation was passed cannot be the result of the DHA's operation.

4. Increased PIP Payments

The Mercer Methodology includes savings purporting to represent the time value of money stemming from hospitals' receipt of increased PIP payments "early." (Mercer Report at 27-28). The inclusion of this category of purported savings is inappropriate for three reasons.

First, the PIP payments are payments made in connection with the Medicaid program. the DHA, however, is not the single state agency authorized by the federal government to administer the Medicaid program in Maine; that distinction belongs to the Office of MaineCare Services of the Department of Health & Human Services.

Second, the time value of money is not related to the operation of the DHA. Not even Mercer, with its broad view of the cost savings properly included in the calculation of AMCS, suggests that the PIP payments themselves have any relationship to the operation of the DHA. Indeed, in the proceeding before the Superintendent regarding the First Assessment Year, Mr. Schramm admitted that the PIP payments would have been made to hospitals even in the absence of Dirigo. See Transcript of 10/27/05 Evening Session in Docket No. INS-05-700 at 49. The time value of money has nothing more to do with the operation of the DHA than do the payments on which they were based, unless of course the DHA is now responsible for interest and inflation.

Third, despite the fact that Mercer has stated that it has all of the data it needs (Mercer Report at 28-29), the Mercer Methodology does not adequately identify the manner by which Mercer plans to determine the time value of money associated with the receipt of the increased PIP payments. The ultimate calculation of the time value of money attributable to the increased PIP payments is necessarily dependent upon how "early" the hospitals received the payments. (Mercer Report at 28). Despite the fact that all of the information Mercer needs to perform the

calculation is "currently available" (Mercer Report at 28-29), Mercer identifies neither how "early" the hospitals received the payments nor the appropriate rate of interest to be applied. Mercer should not be permitted to place "mystery meat" on the menu, particularly when it has all of the data needed to fully describe the dish.

5. Increased Medicaid Payments

An increase in Medicaid payments to physicians has nothing to do with the DHA, much less its operation as a health insurance provider. The increase in physician payments is attributable to the recommendations of the Commission to Study Maine's Community Hospitals, which was created by the Act, specifically P.L. 2003, ch. 469, § F-3(1). The Commission to Study Maine's Community Hospitals, however, is independent from the DHA, and, in fact, the DHA is not even referenced in Part F of Chapter 469. Also, like the increased PIP payments, the increased Medicaid Payments are made pursuant to the Medicaid program administered by the Office of MaineCare Services. AMCS does not include items simply because they are related in some fashion to the Act.

C. The DHA Cannot Reserve The Right To Modify Its AMCS Methodology

Throughout its methodology, Mercer laments the fact that information that it contends is necessary to calculate AMCS is unavailable at this time. Despite the purported lack of data, Mercer states on several occasions that "[t]he unavailability of this data makes it impossible to determine the savings amount at this time; however, *the methodologies for calculation can be established.*" (Mercer Report at 1, 6, 7) (emphasis added). That having been said, Mercer, and its client, the DHA, seek to keep their options open by reserving the right to make "some adjustments when the final data is utilized." (Mercer Report at 9).

Procedural Order No. 3, however, does not allow the DHA to file an AMCS methodology to serve as a placeholder for some modified variant to be sprung upon the other parties at some unspecified future date. Rather, the Procedural Order, as modified by the Hearing Officer's oral order at the March 14, 2006 hearing on the DHA's motion to continue, clearly obligates the DHA to file "a detailed description of the methodology ... and credible, reliable and accurate data that supports the amount of [AMCS] derived from the methodology" on March 20, 2006. (Procedural Order No. 3 at 3).

Moreover, the stated justification for researching the right to modify the methodology—the alleged lack of data—is specious.[1] The validity of the Mercer Methodology as an actuarial and mathematical model is in no way dependent on the raw data to be analyzed. Imagine suggesting that the validity of the Pythagorean Theorem could depend on whether A equals 5, rather than 3. If the Mercer Methodology is truly a legitimate method of calculating AMCS, Mercer and the DHA should be willing to simply insert the data and let the chips fall where they may.[2] The only purpose for leaving the door open to future modification in light of after-acquired data is to provide the DHA with the opportunity to create and present a new methodology if the Mercer Methodology fails to yield an AMCS figure to its liking.

II. CONCLUSION

For all of the foregoing reasons, the Board should hold that the Dirigo Health Agency has failed to prove the existence of any aggregate measurable cost savings as the result of the operation of Dirigo Health during the Second Assessment Year.

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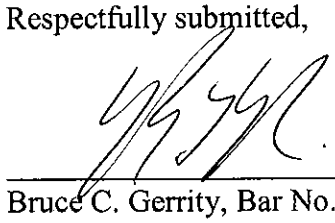
[1] For at least two of the categories of savings included in the Mercer Methodology; *i.e.*, increased PIP and Medicaid payments, Mercer has specifically stated that it has all the data it needs. (Mercer Report at 28-29).

[2] This unwillingness by the DHA to lay its cards on the table is a defense mechanism; after all, Mercer's methodology for the First Assessment Year was discredited by the fact that it produced savings in New Hampshire, and quite likely in Uzbekistan.

Dated: March 24, 2006

Respectfully submitted,



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CERTIFICATE OF SERVICE

I hereby certify that by 5:00 p.m. on March 24, 2006, I served the above filing on the following parties and counsel of record as follows:

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Dated: March 24, 2006

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